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GOVERNMENT OF DUBAI

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DUBAI HEALTH AUTHORITY

DHA Health Facility Guidelines 2019

Part B – Health Facility Briefing & Design

300 – Mental Health Unit – Older Persons

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Executive Summary

This Functional Planning Unit (FPU) covers the requirements of an Older Persons Mental Health Unit to provide assessment, inpatient accommodation and treatment for acute mental health patients. Accommodation may be provided in Open Care Units or in a secure, High Dependency Unit. The Older Persons, also referred to as Geriatric Mental Health Unit may be provided as a Unit within a hospital, on a hospital campus or a stand-alone facility.

The Older Persons Mental Health Unit is arranged in Functional Zones that include Entry/ Reception and Waiting, Inpatient/ Therapy Areas, Clinical Support Areas that may be shared between Mental Health Units and Staff Areas.

The Functional Zones and Functional Relationship Diagrams indicate the ideal external relationships with other key departments and hospital services. This includes relationships with other mental health service units, Emergency Units, primary care mental health services and Police. Optimum internal relationships are demonstrated in the diagram according to the Functional Zones whilst indicating the important paths of travel.

Design Considerations address a range of important issues including providing a therapeutic environment for mental health patients, acoustics, balancing the need for privacy with safety and security, building services requirements and infection control. Ensuring the building fabric and fittings are impact resistant and ligature points are minimised are key issues.

The Schedules of Accommodation are provided using references to Standard Components (typical room templates) and quantities for a typical unit with 16 beds (2 x 8 bed modules) for Role Delineation Level (RDL) 4 to 6.

Further reading material is suggested at the end of this FPU but none are mandatory.

Users who wish to propose minor deviations from these guidelines should use the **Non-Compliance Report** (**Appendix 4 in Part A**) to briefly describe and record their reasoning based on models of care and unique circumstances.

The details of this FPU follow overleaf.

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300. Mental Health Unit – Older Persons

1 Introduction

1.1 Description

The function of the Older Persons Mental Health Unit is to provide appropriate facilities for the reception, multidisciplinary assessment, admission, diagnosis and treatment of patients presenting with known or suspected psychiatric conditions and behavioural disorders along with assessment of physical health and psycho-social issues. Patients may be admitted on a voluntary or involuntary basis; possible referral to this Mental Health Unit could come via PEC (emergency) or via non-PEC. Treatment is focused on clinical symptom reduction with a reasonable expectation of substantial improvement in the short term.

The Unit must provide a safe, restorative environment. Optimal physical environments are associated with shorter lengths of stay, lower levels of aggression and critical incidents, better client outcomes and better staff conditions and satisfaction. Recurrent costs will be substantially reduced, and client services and outcomes improved in such settings.

Some patients may be agitated, aggressive and potentially a risk to themselves or others, including staff. The Unit must therefore provide a high level of security and the capacity for observation and even temporary containment. However, this should be achieved with a therapeutic focus so that while necessary measures for safety and security are in place, they are non-intrusive and do not convey a custodial ambience.

It must be stressed that Older Persons Mental Health Units are not “dementia” Units but they should be able to accommodate people with dementia, confusion and disturbed behaviour appropriately.

1.2 Target Group

The target group for these services will comprise of older people who:

- Develop or are at high risk of developing a mental health disorder at the age of 65 years and over, such as depression, psychosis, anxiety or a severe adjustment disorder
- Have had a lifelong or recurring mental illness, and now experience age-related problems causing significant functional disability (i.e. become 'functionally old')
- Have had a prior mental health problem but have not seen a specialist mental health service for at least five years and now have a recurrence of their illness or disorder that can be optimally managed by Older Persons Mental Health Unit
- Present with severe behavioural or psychiatric symptoms associated with dementia or other long-standing organic brain disorder and would be optimally managed with input from Older Persons Mental Health Units. This may include people who are deemed at risk of harm to themselves or to others. Symptoms may include:
  - Major depression
  - Severe physical and/or verbal aggression
  - Severe agitation
  - Screaming
  - Psychosis

The families and carers of these older people are also part of the broader target group for Older Persons Mental Health Units.

1.2.1 Client Profile

- Robust elderly (although an Adult Acute Unit may be more suitable in some cases);
- Frail elderly
- Violent/ disturbed elderly

Patients may have;

- Tendency to wander, become lost or abscond
- Reduced personal and social skills and require assistance with personal hygiene, dressing, toileting and eating
- Disturbed or aggressive behaviours (verbal / physical)
- Confusion, bewilderment, agitation, memory loss
- Repetitive, persistent or noisy behaviour
- Resistance to care
- Withdrawn behaviour
- Intentional self-harming behaviour
- Physical co-morbidity

Clinical conditions of patients;

- Schizophrenia and psychotic disorders;
- Dementia (incl. Alzheimer' disease) with severe behavioural and psychological symptoms
- Depression, anxiety and mania
- Potential suicide
- Underlying co-morbidities

Regardless of diagnosis, patients may be described as "hyperactive" or "hypoactive" and it is this description that may determine appropriate bed placement within the Unit.

2 Functional & Planning Considerations

The Older Persons Mental Health Unit operates on a 24 hour per day basis. Specific Clinical Service Operational Models are dependent on the endorsed clinical service plan, the patient mix, number of beds and the Model of Care to be adopted.

2.1 Planning Models

2.1.1 Location

It is highly desirable to locate the Older Persons Mental Health Units on ground floor, in order to provide necessary secure outdoor areas.

2.1.2 Configuration

The Older Persons Mental Health Units it may be developed as:

- A stand-alone Inpatient Unit - or group of units – usually as part of a Mental Health Complex.
- A dedicated Inpatient Unit within a general hospital.
- A number of dedicated Patient Bedrooms as an annexe to an Acute Inpatient Unit within a general hospital.

2.1.3 Unit Design

The following principles should be applied:

- Reduce the size of the patient groups
- Make the environment as familiar as possible
- Make the environment as domestic as possible
- Make the environment safe and secure
- Make the environment simple, with good visual access
- Reduce unnecessary stimulation

- Highlight helpful stimuli
- Provide for planned wandering
- Provide opportunities for both privacy and community, i.e. a variety of social spaces
- Provide for visitors, i.e. links to the community

2.1.4 Layout

Consideration should also be given to the following issues when planning the layout of a Mental Health Unit:

- Prevalence of violence and theft
- Availability of qualified staff
- Need for space, light and a functional layout
- Changes in the composition of the patient population
- Rapid changes in technology
- Maximising efficiencies in recurrent /operating costs

The final layout of a mental health unit will reflect the interplay between the following factors;

- The interplay between inpatient and ambulatory care services in the Health Service model of service delivery
- Special needs of potential patients
- The effect of mixing mental health and non-mental health clients
- Proximity to Emergency Unit
- Lines of sight – along corridors and across recreational and common areas into courtyard
- Dead-end corridors where patients may be unable to be seen must be avoided and consideration must be given to safe and supervised access for housekeeping, catering,

maintenance, security, contractors and other staff who may feel uncomfortable in the mental health environment

3 Unit Planning Models

The Unit will commonly be located at ground level to provide access to outdoor recreational areas for patients. A Unit within a multi storey building will require the consideration of difficulties in patient movement into and out of the Unit and the ability to provide sufficient functional external space for the clients.

3.1 Functional Zones

The Older Persons Mental Health Units will comprise a number of Zones as follows:

- Entry/ Reception with
  - Waiting areas
  - Consult/ Interview rooms
  - Meeting Room
  - Offices for administration
- Inpatient/ Therapy Areas including:
  - Patient Bedrooms with Ensuites
  - Dining/ Lounge/ Activity areas
  - Recreation areas including outdoor areas
  - Patient Laundry; optional, depending on acuity

  Within the Inpatient/ Therapy Area, Day and Sleeping Zones should be separated from each other
- Clinical Support Areas including
  - Staff Station and hand-over space
  - Medication / Treatment room
  - Clean and Dirty utilities
  - Store rooms

- Staff Areas:
  - Offices for administrative and management
  - Meeting Room
  - Staff Room
  - Staff Amenities, Toilets and Property Bays

These zones are discussed briefly below.

3.1.1 Main Entry/ Reception Area

These areas are designated for the reception of all persons entering the Unit with the exception of involuntary admissions who will access the unit via a separate Secure Entry (if provided), and deliveries and staff from within the Hospital itself.

A safe environment must be provided for staff in this workspace while providing a welcoming ambience for patients and others. Direct access for reception staff to a safe retreat in an adjacent secure area should be provided in the case of any threat to staff safety from persons arriving at the main entry.

3.1.2 Patient Bedrooms

Generally single bedrooms are recommended but it may be appropriate to include one or two 2 bed rooms in order to assess a patient's ability to socialise once discharged particularly if returning to shared accommodation in a Nursing Home or similar.

Ideally adjustable hi-lo beds be selected for the unit; "hi" adjustable bed position to assist nursing staff in patient care and bed making; "lo" adjustable bed position when patients are resting/sleeping to minimise falls.

A personal display board and lockable storage for personal clothes/ belongings should be provided in bedroom.

One or two bedrooms acoustically treated and contained for very agitated "screaming" patients.

3.1.3 Ensuites

Most bedrooms should have a dedicated Ensuite shower/ toilet. However, consideration may be given to having a one or two fully accessible showers and toilets apart from the bedrooms for use by patients occupying recreational areas.

Size and design of these rooms are crucial as it is a high-risk area for both agitated patients and staff and as far as possible, design should be such as to make the showering experience safe and pleasant.

Fixtures and fittings should be securely attached and designed so as to provide no possibility for self-harm or use as a weapon. Refer to Fixtures and Fittings Section for details.

3.1.4 Staff Station & Staff Handover

Ideally staff station & staff handover areas should be a single space oversighting all inpatient zones. Conflict of observation versus confidentiality should be reviewed.

3.1.5 Medication/ Treatment Room

If appropriately sized and equipped, a single room can serve the following functions;

- Examination and procedures that may be best undertaken away from the bedside
- Visual acuity testing; storage & use of ophthalmoscope & auroscope
- X-ray viewing (screens or PACS monitor)
- Medication storage and distribution
- Storage of medical / surgical consumables and sterile supplies
- Storage of resuscitation trolley and defibrillator
- Provision of a hand basin is essential

Direct access from the Staff Station for access control and second locked access from the Unit corridor is recommended.

3.1.6 Courtyards/ Gardens

When designing courtyards and gardens the following requirements need to be considered;

- Oversighted by the Staff Station
- Controlled access for patients, preferably from recreation area/s
- Separate discreet access for gardeners and maintenance staff
- Weather-protection to allow use during inclement weather (agitation may increase if no external access)
- Shade cloth and sun protection.
- No footholds on fences. (Fencing height to be addressed)

3.1.7 Occupational Therapy Room

The Occupational Therapy Room should be multi-purpose, in design and fit-out, to allow varied activities aimed at promoting independence in daily living. Functions and activities involve:

- Activities of daily living (ADLs) assessment and retraining
- Ergonomic assessment
- Sensory, perceptual, cognitive and motor assessment and therapy
- Group treatments
- Leisure activities
- Social interaction

Ideally the occupational Therapy Room may be adjacent to the multifunction activity Room and may share a common movable wall. This would enable the potential for a large space if required.

Fittings and furniture for this area should include;

- Emergency call
- Stainless steel sink
- Clock
- Domestic style furnishings that may include chairs, tables and plinth
- Wall and door protection for chairs and wheelchairs
- Handbasin

4 Functional Relationships

A Functional Relationship can be defined as the correlation between various areas of activity which work together closely to promote the delivery of services that are efficient in terms of management, cost and human resources.

4.1 General

Acute mental illness in older people may be accompanied by co-morbid physical health or medical issues and is sometimes complicated by delirium. Therefore, acute episodes of illness frequently persist much longer than the four or five days common in adult mental health or general acute inpatient units, and patients require follow-up care. Older Persons Mental Health Units thus need to be supported by acute geriatric medical services and appropriate non-acute services, including non-acute mental health inpatient facilities, specialist residential aged care facilities with adequate mental health expertise or input and adequate acute and non-acute services for older people with medical issues, delirium and dementia.

4.2 External Relationships

The Older Mental Health Unit will have a close relationship with other Units including:

- Community Centres
- Residential Aged Care Facilities
- General Practitioners
- Emergency Unit / PECC
- Adult Acute Mental Health Unit
- Acute Geriatric Inpatient Unit
- Medical Imaging
- Outpatient clinics
- Pathology
- Linen, Catering, Stores etc.

The optimum External Relationships include:

- Good access to patient referral facilities including Community Centres
- Access to Ambulance and patient transport drop off points for patients coming from Residential Aged Care Facilities who may be physically impaired
- Access for patient who are brought in by ambulance from facilities such as General Practitioners

4.3 Internal Relationships

The internal planning of the Adult Mental Health Unit should be designed by considering the Functional Zones within the Unit.

Optimum Internal Relationships should include the following:

- Reception and Waiting at the entrance with access to a mental health Consult Room
- Consult and Examination Rooms located near the entry to allow discussions and reviews

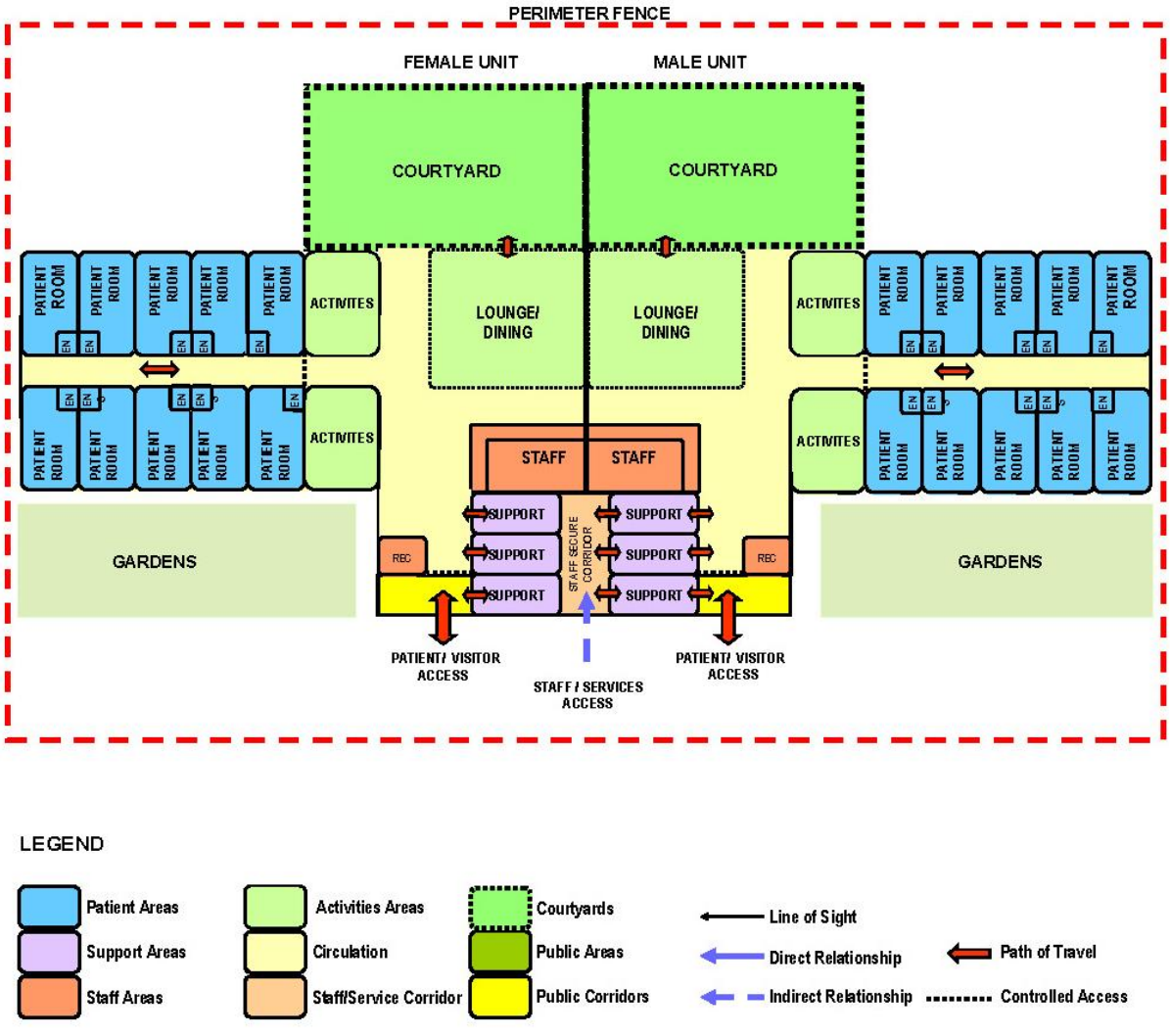
without entering the Unit

- Patient Bedrooms located on the perimeter and separate4 to communal dining and activity areas
- Dining, Lounge and Activities Areas centrally located
- Staff Station located with visibility to all patient zones
- Support Areas located close to staff areas for ease of staff access
- Staff Offices and amenities located in a secure zone away from patient areas
- Visitors Lounge located in the perimeter of the unit. Visitors can come into this directly without going through the unit. Observation by staff is required, and can be administered via CCTV rather than direct visual observation

It is important for the Functional Zones to work effectively together to allow for an efficient, safe and pleasant environment.

4.4 Functional Relationships Diagram

The relationships between the various components within the Older Persons Mental Health Unit are best demonstrated in the diagram below.



5 Design Considerations

Elderly patients admitted to hospital units are more likely to have multiple chronic illnesses and co-morbidities leaving them at higher risk of functional decline. Unit design should take into consideration providing an environment for patients in which they feel comfortable, familiar and stimulated with access to activities of daily living (ADLs).

5.1 Environmental Considerations

5.1.1 Acoustics

The Unit should be designed to minimise the ambient noise level within the unit and transmission of sound between patient areas, staff areas and public areas.

Consideration should be given to location of noisy areas or activity away from quiet areas including patient bedrooms and selection of sound absorbing materials and finishes.

Acoustic treatment will be required to the following:

- Day areas such as patient living, dining and activities areas
- Consulting Rooms
- Admission Area

In acoustically treated rooms, return air grilles should be treated to avoid transfer of conversations to adjacent areas. Door grilles to these areas should be avoided.

Low stimulus environments have been proven to reduce distress and agitation in confused or disorientated patients. Bedrooms may be acoustically treated and contained for the benefit of very agitated and noisy patients.

Refer also to Part C of these Guidelines.

5.1.2 Natural Light/ Lighting

The provision of natural light is important particularly in the management of dementia. Natural Light has calming effect, affects sleeping patterns of patients.

Elderly patients require three times as much light as people aged 20 – 30. Abrupt changes in light exposure can impair patient's ability to focus and in turn leaves patient at risk of injury, falls and loss of balance. Similarly, glare can negatively impact the time it takes for an older person's eyes to adjust and may be blinding. Falls at night pose a grave risk to older persons and is the most prevalent time the elderly sustains injuries, attempting to toilet themselves in the dark. Nightlights

placed along corridors, outside bathroom doors and illuminating switches for bathroom lights can drastically reduce these risks.

Care should be taken with sensor lights in – for example – bathrooms – as they have been known to confuse and frighten patients with dementia.

5.1.3 Privacy

The design of the Inpatient Unit needs to consider the requirement for staff visibility of patients while maintaining patient privacy. Unit design and location of staff stations will offer varying degrees of visibility and privacy. The patient acuity including high dependency, elderly or intermediate care will be a major influence.

Factors for consideration include:

- Use of windows in internal walls and / or doors
- Location of beds that may affect direct staff visibility
- Provision of bed screens to ensure privacy of patients
- Location of sanitary facilities to provide privacy for patients while not preventing observation by staff

5.1.4 Interior Design/ Décor

Decor can be used to prevent an institutional atmosphere. Décor can be utilised to aid patients feel comfortable in the hospital environment, provide a sense of familiarity and sensory cues for people who are disorientated and confused.

Interpretations and "research" on the use and value of colour in the clinical area differ; some issues are obvious, others less so and often not backed up by empirical evidence. Consider the following:

- Some colours, particularly the bold primaries and green should be avoided as many people

find them disturbing.

- Extremes of colour and pattern such as geometric designs which may disturb perception should be avoided. However, strong colours on floors may assist in orienting patients to their bedroom cluster etc.
- Colours and interior design should also be chosen to reflect the tastes and age of patients who will use the facility.
- Re-decoration is not a budgetary priority so care in selection of materials and colour is important in the first instance.
- Wall colour should be different to floor colour to define floor plan.
- Consider use of colour and stepping of ceiling heights to provide node points along corridors and to define seating alcoves.

5.2 Accessibility

Ensure all Waiting Areas, Meeting Rooms, Consult, Examination and Assessment Rooms will accommodate patients/ visitors in wheelchairs. The provision of at least one fully accessible Patient Bedroom with Ensuite in the general unit should be considered.

Units shall be designed and built in such a way that patients, staff, visitors and maintenance personnel are not exposed to avoidable risks of injury.

5.3 Doors

Doors and door frames should be impact resistant. All doors except those in Ensuites should be fitted with vision panels of a suitable impact resistant glass. Where privacy is required, vision panels are to be covered or obscured, this can be achieved by the use of integral venetians or slide panels. The doors may also provide a ligature point which must be considered; doors are not required to patient wardrobes to minimise ligature points.

Door hardware must not provide points for ligature or avoidable injury.

5.4 Size of the Unit

The number of beds will be determined by the Service Plan but the larger a facility the more confusing it is likely to be for some patients.

Bedrooms may be grouped into clusters that can be defined for distinct patient groups such as male and female patients who may feel threatened if in close proximity to the opposite sex or "hyperactive" and hypoactive" patients. Small groups of bedrooms with an adjacent recreational space will allow better management of changing patient needs and flexibility of use.

5.5 Safety and Security

Safety and security involves people and policies as well as physical aspects but the latter must be built in as part of overall design and not superimposed on a completed building and surrounding outdoor areas. A safety audit via a risk analysis of potential hazards should be undertaken during the design process.

The Unit must not only be safe, it must feel safe. Security may be physical or psychological and barriers may be real or symbolic, but all must be unobtrusive.

Within this context, the least restrictive environment that still provides a safe environment should be the goal.

The following aspects need to be considered:

- Safety of patients, staff and visitors
- Patients' legal rights
- The status of the hospital or part thereof under relevant Mental Health regulations and legislation in force at the time of development.

5.5.1 Physical Security Aspects

Include the following;

- Access control
- Containment (if and when necessary)
- Good sight lines and avoidance of isolated spaces for both patient and staff safety (e.g. no unsupervised blind corridors)
- Fittings that minimise the opportunity for patient self-harm or injury to staff
- Smooth finishes and rounded edges
- Use of impact-resistant glass
- Arrangement and design of rooms and furniture that prevents barricading
- A communication system which enables staff to signal for assistance from other staff as required via personal and fixed duress alarms
- Impact resistant wall materials
- Sound attenuation

5.5.2 Access Control

Design should assist staff to carry out their duties safely and to supervise patients by allowing or restricting access to areas in a manner which is consistent with patients' needs/ skills. Staff should be able to view patient movements and activities as naturally as possible, whenever necessary.

Security features are required at all entrances and exits. These may include electronic locking, intercoms, and video surveillance.

Controlled and/ or concealed access will be required as an option in a number of functional areas. Such controls should be as unobtrusive as possible.

All Meeting, Counselling, Group Therapy, Family Therapy and Review Board Meeting rooms require two means of egress and a duress alarm.

When the Unit is located within a multi-storey building, access to external spaces above ground level such as balconies or roof is to be prevented.

The perimeter security of the outdoor area surrounding the building is important in reducing staff anxiety in relation to patients' movement and safety and patient privacy.

5.5.3 Video Security

The use of video surveillance may be useful for monitoring areas such as stairways and blind spots, seclusion rooms, hallways and entrances. It is not an appropriate alternative to observation of patients by clinical staff and staffing levels should be sufficient to ensure that reliance is not placed on such electronic surveillance.

When considering the use of video security, the following factors should be considered;

- The rights of patients to privacy balanced against the need to observe activities for safety and security reasons
- The ability of the staff establishment to manage the level of observation required without video security
- The maintenance costs involved

5.6 Finishes

The aesthetics are to be warm and user-friendly wherever possible. Surface finishes should be impact resistant and easily cleaned. Floor finishes are to be non-clinical where possible and easy to maintain.

Finishes including fabrics, floor, wall and ceiling finishes, should be selected with consideration to infection control, ease of cleaning and fire safety, while avoiding an institutional atmosphere.

In areas where clinical observation is critical such as bedrooms and treatment areas, colour selected must not impede the accurate assessment of skin tones.

5.7 Curtains/Blinds

5.7.1 Windows and Glazing

In areas where damage to glass may be anticipated, avoid larger pane sizes- as smaller panes are inherently stronger for a given thickness than larger panes.

Impact-resistant safety glass to comply with local standards is recommended. Polycarbonate is not recommended as it suffers from surface scratching and deteriorates thus reducing vision.

Where windows are operable, effective security features such as narrow windows that will not allow patient escape, shall be provided. Locks, under the control of staff, shall be fitted.

Also refer to **Part C - Access, Mobility, OH&S** of the Guidelines.

5.8 Fixtures, Fittings and Equipment

5.8.1 Safety Principles

Fittings and fixtures selected for Mental Health Units should also be assessed to ensure they do not create any additional safety hazards for staff. All fittings must be suitable for mental health facilities which are anti-ligature types.

These guidelines in respect to Fixtures and Fittings do not negate the need for close observation of patients deemed as at risk, or for clinical care appropriate to the acuity of the patients.

While these guidelines may refer to the provision of specific fittings or fixtures, they may not always be required. For example, coat hooks and towel rails are not necessary. Alternatives such as a bench or cupboard may be adequate to meet the patient's needs.

Due to the impossibility of observing all patients at all times, in areas which patients occupy or to which they have access, utmost care must be taken in selection of fixtures and fittings and their potential to be used as ligature points. They must also be assessed for their potential to be used as a weapon or other means of self-harm. Toughened and laminated and glass that are tinted and double-glazed with integral venetians are recommended.

Fittings and fixtures should be safe, durable, tamperproof, and concealed where possible. They must be flush with the surfaces to which they are attached or designed in a way that prevents attachment of anything around them e.g. cords or belts. It is critical to ensure that if anything is or can be attached to the fitting or fixture; it will break away when weight of 15-20kg is applied.

5.8.2 Shower Curtains and Tracks

Where installed, shower tracks should be plastic and mounted flush to the ceiling to prevent the possibility of attaching anything such as cords, belts etc.

If installed, it is critical to ensure that the entire track plus hooks has a 15-20kg breaking strain to ensure that if curtains are gathered into a single cluster the aggregate does not exceed 15-20kgs

If curtain hooks are able to be "pushed" together then they should not be installed as this will increase the breaking strain far beyond the 20kg as outlined.

If the fall-to-floor ratio of the floor drains in showers is adequate to prevent flooding, the provision of shower curtains may be avoided but consideration needs to then be given to dry storage for towels etc. Flooring in and around the cubicle must be non-slip.

5.8.3 Window Treatments

Curtains, Holland blinds or any type of blinds or curtains with cords should not be used in patient bedrooms. However, alternative means of providing privacy must be considered. Enclosed Venetian blinds with flush controls or electronic controls in staff station are a preferred option where privacy and sun shading are required.

If curtains are selected for use in patient recreational areas, the tracks must be flush to the ceiling and have a breaking strain of 15-20 kg (as for shower curtains). Consideration should also be given to fabric type, with respect to weight/thickness and how easily it tears.

Ideally external shading of windows (eaves, awnings etc.) addressing environmental considerations should be the preferred option while applying the same safety principles for fittings and fixtures.

5.8.4 Rails, Hooks and Handles

The use of horizontal grab rails in toilets and showers should be avoided; solid, vertical rails with moulded hand grip are preferred. Alternative provision of towel storage, such as a bench, can be considered to avoid use of towel rails or hooks. Where rails or hooks are provided, they must comply with a breaking strain of 15-20 kg.

Door and cupboard handles/ knobs should be of a design that does not provide ligature points. Fittings moulded to incorporate hand pulls should be investigated to avoid use of handles altogether.

5.8.5 Plumbing Fixtures

Consideration should be given to the following items;

- Shower heads should be flush with the wall
- Taps must not be able to be used as ligature points
- Exposed services such as sink wastes which may be easily damaged should be avoided

- Toilet cisterns should be enclosed behind the wall
- Toilet seats should resist breakage and removal

5.8.6 Heating/ Cooling

Consideration shall be given to the type of heating and cooling units, ventilation outlets, and equipment installed in patient-occupied areas of Mental Health Units. Special purpose equipment designed for psychiatric use shall be used to minimise opportunities for self-harm. The following shall apply;

- All air grilles and diffusers shall be of a type that prohibits the insertion of foreign objects
- All exposed fasteners shall be tamper-resistant
- All convector or HVAC enclosures exposed in the room shall be constructed with rounded corners and shall have closures fastened with tamper-resistant screws
- HVAC equipment shall be of a type that minimises the need for maintenance within the room

Air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity.

5.8.7 Artwork, Signage and Mirrors

Artwork and signage should be rigidly fixed to walls with concealed, flush, tamper-proof mountings. Artwork based on non-tearable fabric may be considered.

Mirrors shall be of safety glass or other appropriate impact-resistant and shatterproof construction but free from distortion. They shall be fully glued to a backing to prevent availability of loose fragments of broken glass.

5.8.8 Furniture

Loose furniture should be sturdy and heavy enough to prevent injury to patients of staff.

Design of furniture – especially of beds - should minimise any risk of use as a low ligature point while also being adjustable to reduce the risk of patients of varying heights sustaining injuries getting into or out of bed.

5.8.9 Ceiling Fittings

Light fittings, smoke and thermal detectors, CCTV cameras where used and air-conditioning vents to secure areas, particularly the seclusion rooms (if provided) should be vandal-proof and incapable of supporting a patient's weight.

Air conditioning vents should be fixed to the ceiling to prevent access to the roof cavity

5.9 Building Services Requirements

This section identifies unit specific services briefing requirements only and must be read in conjunction with **Part E - Engineering Services** for the detailed parameters and standards applicable.

5.9.1 Information Technology/ Communications

Unit design should address the following Information Technology/ Communications issues;

- Electronic Health Records (EHR) which may form part of the Health Information System (HIS)
- Hand-held tablets and other smart devices
- Paging, intercom and personal telephones replacing some aspects of call systems
- Electronic supplies management systems
- Data and communication outlets, servers and communication room requirements
- Wireless network requirements
- Videoconferencing requirements for meeting rooms

5.9.2 Staff Call

Hospitals must provide an electronic call system that allows patients and staff to alert nurses and other health care staff in a discreet manner at all times.

The need for and type of patient call system should be reviewed. In bedrooms, it will need to be a call button that may not always be in easy reach, systems can be abused, and most patients are ambulant and capable of asking for assistance.

Staff assist, and psychiatric emergency calls can be handled via personal duress alarms. Medical emergencies require access to the hospital's cardiac arrest system.

5.9.3 Duress Call

The provision of both fixed and individual mobile duress equipment with location finders should be considered and planned for early in the project.

5.9.4 Heating Ventilation and Air-conditioning (HVAC)

The Unit should be air-conditioned with adjustable temperature and humidity for patient comfort.

All HVAC units and systems are to comply with services identified in Standard Components and **Part E – Engineering Services**.

5.9.5 Hydraulics

Avoid exposed services; for example, sink wastes which may be easily damaged or used as ligature points. Toilet cisterns should be enclosed behind the wall, Shower heads should be flush to the wall and downward facing and taps without ligature points.

Warm water must be supplied to all areas accessed by patients within the Unit. This requirement includes all staff handwashing basins and sinks located within patient accessible areas.

Refer to **Part E - Engineering Services** for details.

5.10 Infection Control

The infectious status of many patients admitted to the Unit may be unknown. All body fluids should be treated as potentially infectious and adequate precautions taken accordingly.

5.10.1 Hand Basins

Handbasins for staff hand washing are required in treatment areas and Medication Room; they only need to be places at the staff station and not at patient areas. Basins in patient areas should have a shroud or cover to plumbing and tapware and outlets must not provide ligature points, sensor or push button operated tapware is recommended.

5.10.2 Antiseptic Hand Rubs

Corridor handbasins may be replaced with Antiseptic Hand Rub dispensers, depending on infection control policies. Antiseptic Hand Rubs are to comply with **Part D - Infection Control**, in these guidelines. Antiseptic Hand Rubs, although very useful and welcome, cannot fully replace Handwash Bays. There should only be located at staff staions, and out the entrance of the unit; they are not required in patient areas. A combination of both are required.

Refer to **Part D – Infection Control** for additional details.

6 Standard Components of the Unit

Standard Components are typical rooms within a health facility, each represented by a Room Data Sheet (RDS) and a Room Layout Sheet (RLS).

The Room Data Sheets are written descriptions representing the minimum briefing requirements of each room type, described under various categories:

- Room Primary Information; includes Briefed Area, Occupancy, Room Description and relationships, and special room requirements)

- Building Fabric and Finishes; identifies the fabric and finish required for the room ceiling, floor, walls, doors, and glazing requirements
- Furniture and Fittings; lists all the fittings and furniture typically located in the room; Furniture and Fittings are identified with a group number indicating who is responsible for providing the item according to a widely accepted description as follows:

Group	Description
1	Provided and installed by the builder
2	Provided by the Client and installed by the builder
3	Provided and installed by the Client

- Fixtures and Equipment; includes all the serviced equipment typically located in the room along with the services required such as power, data and hydraulics; Fixtures and Equipment are also identified with a group number as above indicating who is responsible for provision
- Building Services; indicates the requirement for communications, power, Heating, Ventilation and Air conditioning (HVAC), medical gases, nurse/ emergency call and lighting along with quantities and types where appropriate. Provision of all services items listed is mandatory

The Room Layout Sheets (RLS's) are indicative plan layouts and elevations illustrating an example of good design. The RLS indicated are deemed to satisfy these Guidelines. Alternative layouts and innovative planning shall be deemed to comply with these Guidelines provided that the following criteria are met:

- Compliance with the text of these Guidelines
- Minimum floor areas as shown in the schedule of accommodation

- Clearances and accessibility around various objects shown or implied
- Inclusion of all mandatory items identified in the RDS

The Older Persons Mental Health Unit will consist of Standard Components to comply with details described in these Guidelines. Refer also to Standard Components Room Data Sheets and Room Layout Sheets.

7 Schedule of Accommodation

The Schedule of Accommodation (SOA) provided below represents generic requirements for this Unit. It identifies the rooms required along with the room quantities and the recommended room areas. The sum of theroom areas is shown as the Sub Total as the Net Area. The Total area is the Sub Total plus the circulation percentage. The circulation percentage represents the minimum recommended target area for corridors within the Unit in an efficient and appropriate design.

Within the SOA, room sizes are indicated for typical units and are organised into the functional zones. Not all rooms identified are mandatory therefore, optional rooms are indicated in the Remarks. These guidelines do not dictate the size of the facilities, therefore, the SOA provided represents a limited sample based on assumed unit sizes. The actual size of the facilities is determined by Service Planning or Feasibility Studies. Quantities of rooms need to be proportionally adjusted to suit the desired unit size and service needs.

The Schedule of Accommodation are developed for particular levels of services known as Role Delineation Level (RDL) and numbered from 1 to 6. Refer to the full **Role Delineation Framwork** (**Part A - Appendix 6**) in these gduielines for a full description of RDL's.

The table below shows a typical SOA for a 16 Bed Unit at RDL's 3 to 6 for acute mental health patients incorporating inpatient, therapy and staff areas. Inpatient areas may be broken into two 8 bedded modules as demonstrated in the functional relationships diagram for gender or patient acuity purposes.

For stand-alone facilities, designers may add any other FPU's required such as Main Entrance Unit, Housekeeping, Supply, Waste Management etc. based on the business model.

Any proposed deviations from the mandatory requirements, justified by innovative and alternative operational models may be proposed and record in the **Non-Compliance Report** (refer to **Part A - Appendix 4**) with any departure from the Guidelines for consideration by the DHA for approval.

7.1 Older Persons Mental Health Units with 16 Bed (2 x 8 bed modules)

ROOM/ SPACE	Standard Component Room Codes									RDL 3-6 Qty x m^2			Remarks
										16 Beds (2 x 8)			
Entry/ Reception													
Airlock – Entry	airle-10-d									1	x	10	Optional
Reception	recl-10-d									1	x	10	
Waiting – (Male/ Family)	wait-20-d									2	x	20	
Parenting Room	par-d									1	x	6	Optional, May share public facilities if located close
Consultation/Interview Room	cons-mh-d									3	x	13	Interview function, family meetings; 1 per 5 beds
Examination/ Assessment	exas-mh-d									1	x	15	1 – 2 per unit depending on size of unit
Meeting Room	meet-l-30-d									1	x	30	Family Conferences, Meetings, reviews.
Toilet – Public	wcpu-3-d									2	x	3	May share public facilities if located close
Toilet – Accessible	wcac-d									2	x	6	May share public facilities if located close
Inpatient/Therapy Areas													
1 Bed Room – Mental Health	1br-mh-14-d									16	x	14	
Ensuite – Mental Health	ens-mh-d									16	x	5	
Medication/ Treatment Room - Mental Health	med-mh-d									1	x	12	
Bay - Handwashing, Type B	bhws-b-d									4	x	1	

ROOM/ SPACE	Standard Component Room Codes									RDL 3-6 Qty x m^2			Remarks
										16 Beds (2 x 8)			
Bay – Linen	blin-d									1	x	2	Enclosed & locked
Dining Room	dinbev-25-d similar									1	x	60	Based on 2.5 m^2 per person (16 Patient & 8 Family members)
Servery/ Trolley Holding (Mental Health)	serv-mh-d									1	x	8	With servery counter, Locate adjacent to Dining Room
Lounge - Activities (Mental Health)	lnac-30-d similar									1	x	50	
Multi-Function Activities Room (Mental Health)	mac-20-d similar									1	x	32	
Occupational Therapy Room	mac-20-d similar									1	x	32	
Courtyard	NS									1	x	*	*External Mandatory area
Laundry – Mental Health	laun-mh-d									1	x	6	Optional
Seclusion Room	secl-d									1	x	12	Optional if location of Observation (secure) unit too remote
Toilet -Staff	wcst-d									1	x	3	Optional if location of main amenities too remote
Toilet - Accessible	wcac-d									1	x	6	Located near Dining Room and Activities areas
Clinical Support Areas													
Staff Station	sstn-14-d									1	x	14	To oversee all sub-units. May sub-divide if necessary
Office - Clinical/ Handover	off-cln-d									1	x	15	
Bay – Resuscitation Trolley	bres-d									1	x	1.5	Locate in Staff Station or Medication/ Treatment Room
Dirty Utility	dtur-12-d similar									1	x	10	
Cleaner's Room	clrm-6-d									1	x	6	
Disposal Room	disp-8-d									1	x	8	Includes recycling bins
Store- Equipment	steq-14-d									1	x	14	
Store - General	stgn-8-d									1	x	8	
Store – Patient Property	stpp-d									1	x	8	
Bathroom	bath-d									1	x	16	Optional , Locked
Staff Areas													
Office – Single	off-s12-d									1	x	12	Director
Office – Single	off-s9-d									1	x	9	Nurse Manager

ROOM/ SPACE	Standard Component Room Codes									RDL 3-6 Qty x m^2			Remarks
										16 Beds (2 x 8)			
Office – Single	off-s12-d									1	x	12	Psychiatrist. No. determined by Staff Establishment
Office - Workstation	off-ws-d									1	x	5.5	Medical Staff, No. determined by Staff Establishment
Office - Workstation	off-ws-d									1	x	5.5	Nursing Staff, No. determined by Staff Establishment
Office - Workstation	off-ws-d									1	x	5.5	Allied Health,Optional No. determined by Staff Establishment
Store – Photocopy/Stationery	STPS-8-D									1	x	8	
Store – Files	STFS-10-D									1	x	10	For Clinical records, Optional if electronic records used
Meeting Room	MEET-L-30-D									1	x	30	
Staff Room	SRM-15-D similar									1	x	20	
Property Bay – Staff	PROP-3-D									1	x	3	
Shower - Staff	SHST-3-D									2	x	3	Optional
Toilet – Staff	WCST-D									2	x	3	
Sub Total												**932**	
Circulation %												**35**	
Area Total												**1258.2**	

Please note the following:

- Areas noted in Schedules of Accommodation take precedence over all other areas noted in the Standard Components
- Rooms indicated in the schedule reflect the typical arrangement according to the sample bed numbers
- All the areas shown in the SOA follow the No-Gap system described elsewhere in these Guidelines
- Exact requirements for room quantities and sizes shall reflect Key Planning Units (KPU) identified in the Clinical Service Plan and the Operational Policies of the Unit
- Room sizes indicated should be viewed as a minimum requirement; variations are acceptable to reflect the needs of individual Unit
- Offices are to be provided according to the number of approved full-time positions within the Unit

8 Further Reading

In addition to Sections referenced in this FPU, i.e. **Part C- Access, Mobility, OH&S** and **Part D - Infection Control** and **Part E - Engineering Services**, readers may find the following helpful:

- AHIA, Australasian Health Facility Guidelines, Part B Health Facility Briefing and Planning, HPU 0135 Older Persons Acute Mental Health Unit, Rev 2 2016, refer to website: https://healthfacilityguidelines.com.au/health-planning-units
- DH (Department of Health) NHS Estates (UK) Health Building Note 35 Accommodation for people with Mental Illness, part 1 – The Acute Unit., 2006; refer to website www.estatesknowledge.dh.gov.uk
- International Health Facility Guideline (iHFG) www.healthdesign.com.au/ihfg
- Ministry of Health UAE, Unified Healthcare Professional Qualification Requirements, 2017, refer to website: https://www.haad.ae/haad/tabid/927/Default.aspx
- The Facility Guidelines Institute (US), Guidelines for Design and Construction of Hospitals, 2018. Refer to website: www.fgiguidelines.org
- The Facility Guidelines Institute (US), Guidelines for Design and Construction of Outpatient Facilities, 2018. Refer to website: www.fgiguidelines.org